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6481
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06394

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle T. Last Buckalew		4. DATE OF DEATH Month June Day 8th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15th, 1949
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementary school	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Buckalew		14. MOTHER'S MAIDEN NAME Mary Jane Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jas. E. Buckalew,		Address Frostburg, Md. 109 Maple St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 280X Diabetic coma- DUE TO (b) Diabetes mellitis uncontrolled DUE TO (c) DAYS-			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN. 1959 to JUNE 8 , 19 60 , that (I) (we) lost saw the deceased alive on 8 JUNE 1960 , and that death occurred at 8 PM , from the causes and on the date stated above.			
22a. SIGNATURE John B. Davis,		22b. DATE SIGNED 6/12/60	
22c. PHYSICIAN'S NAME (Type) John B. Davis, M. D.		22d. ADDRESS 5 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-11-1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) Garrett County	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		25a. REC'D BY REGISTRAR DATE JUN 13 '60	
ADDRESS Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



1381
CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6432

06395

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MORGAN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS BOX 261		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle RICHARD Last BULLETT				4. DATE OF DEATH Month JUNE Day 4 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 16, 1960	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. AGE (In years last birthday) yrs.		12. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PAW PAW, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JACK BULLETT			
14. MOTHER'S MAIDEN NAME SIGLINDE ULLRICH				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kermiteruo DUE TO 756.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atresia of Common Bile Duct DUE TO (c) Birth				INTERVAL BETWEEN ONSET AND DEATH 2 Day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 4, 1960 to June 4, 1960 , that (I) (we) last saw the deceased alive on June 4, 1960 and that death occurred 8:30 PM from the causes and on the date stated above.							
22a. SIGNATURE DR. OVERTON HIMMELWRIGHT				22b. DATE SIGNED 6/6/60			
22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT				22d. ADDRESS 133 VIRGINIA AVE. - CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6/5/60		23c. NAME OF CEMETERY OR CREMATORY Camp Hill	
23d. LOCATION (City, town, or county) (State) PAW PAW, MORGAN W. VA.				23e. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Johnson				25a. REC'D BY REGISTRAR JUN 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

6832

(M)

1 DAY

BOX 100

BULLET

RECEIVED

MAY 10, 1900

WHITE

(1)

CLARK'S METHOD

NEW YORK

8:30 PM

131 YOUNG AVE., CANTON, N. Y.

THOMAS W. LAMONT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6433 **CERTIFICATE OF DEATH** **06396**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLOVUS RUSSELL COX				4. DATE OF DEATH Month Day Year JUNE 9 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 24, 1889	
9. AGE (In years and months) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY SALESMAN		11. BIRTHPLACE (State or foreign country) OHIO, Williamsport	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN COX		14. MOTHER'S MAIDEN NAME DORA BELL CAMPBELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. 215-20-5622		17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 450.1 DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary heart disease DUE TO (c) embolus left femoral artery						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan 1957 to 6/1/60 that (I) (we) last saw the deceased alive on 6/1/60 and that death occurred at 2:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE George M. Simons				22b. DATE SIGNED 6/9/60			
22c. PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS				22d. ADDRESS Algonquin Hotel, Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/11/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE JUN 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

CERTIFICATE OF DEATH

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6434
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06397

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEE Middle Last CUSTER				4. DATE OF DEATH Month JUNE Day 28 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 2-1898	
9. AGE (In years last birthday) 61 yrs.		10. UNDER 1 YEAR Months Days Hours		11. UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CANE OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY DIAMOND CRYSTAL SALT CO.			
11. BIRTHPLACE (State or foreign country) GARRETT CO., MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN CUSTER				14. MOTHER'S MAIDEN NAME MARY BEACHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-1 + 11				16. SOCIAL SECURITY NO. 274-03-9906			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unemia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular disease with DUE TO (c) Chronic nephritis - and Glaucoma bilateral 6 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Appendicitis - acute perforated June 18, 1960 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 18, 1960 to June 28, 1960 that (I) (we) last saw the deceased alive on June 28, 1960 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W.M. Raw M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED June 30, 1960							
22c. PHYSICIAN'S NAME (Type) DR. W.M. RAW 22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 7/1/60			
23c. NAME OF CEMETERY OR CREMATORY CASSELMAN MENNONITE				23d. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT CO MD			
24. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 11 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

CERTIFICATE OF DEATH

6534



DECEASED: [Name] [Address] [City] [State] [Zip]

DATE OF DEATH: [Month] [Day] [Year]

PLACE OF DEATH: [Location]

CAUSE OF DEATH: [Cause]

DR. [Signature]

150 S. CENTRE ST., [City], MO.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6451 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06398
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, nr. Cumberland		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural nr, Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 Valley Road				d. STREET ADDRESS Routel, Valley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUIS EARL DANIELS				4. DATE OF DEATH June 3 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Kelly-Springfield Tire Co.		11. BIRTHPLACE (State or foreign country) Nr. Chaneyville, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Daniels				14. MOTHER'S MAIDEN NAME Deleva Hartsock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes 1919-1923				16. SOCIAL SECURITY NO. 309-26-7477		17. INFORMANT Mrs. Vifginia H. Daniels	
				Address Rt. 1, Valley Rd. Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Asphyxiation DUE TO Auto exhaust Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 Hr. (c) 1 Hr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Self induced--ran car in closed garage.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self induced--ran car in closed garage.			
20c. TIME OF INJURY Hour 3:00 p. m. June 3 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home garage		20f. (City or town) (County) (State) Rural Rt. Cumberland, All. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarolic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarolic M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 4, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR JUN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Examiner	
11. Signature of Physician		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Registrar		15. Signature of Burial Officer	
16. Signature of Undertaker		17. Signature of Funeral Home		18. Signature of Cemetery		19. Signature of Burial Place		20. Signature of Burial Officer	
21. Signature of Burial Officer		22. Signature of Burial Officer		23. Signature of Burial Officer		24. Signature of Burial Officer		25. Signature of Burial Officer	
26. Signature of Burial Officer		27. Signature of Burial Officer		28. Signature of Burial Officer		29. Signature of Burial Officer		30. Signature of Burial Officer	
31. Signature of Burial Officer		32. Signature of Burial Officer		33. Signature of Burial Officer		34. Signature of Burial Officer		35. Signature of Burial Officer	
36. Signature of Burial Officer		37. Signature of Burial Officer		38. Signature of Burial Officer		39. Signature of Burial Officer		40. Signature of Burial Officer	
41. Signature of Burial Officer		42. Signature of Burial Officer		43. Signature of Burial Officer		44. Signature of Burial Officer		45. Signature of Burial Officer	
46. Signature of Burial Officer		47. Signature of Burial Officer		48. Signature of Burial Officer		49. Signature of Burial Officer		50. Signature of Burial Officer	
51. Signature of Burial Officer		52. Signature of Burial Officer		53. Signature of Burial Officer		54. Signature of Burial Officer		55. Signature of Burial Officer	
56. Signature of Burial Officer		57. Signature of Burial Officer		58. Signature of Burial Officer		59. Signature of Burial Officer		60. Signature of Burial Officer	
61. Signature of Burial Officer		62. Signature of Burial Officer		63. Signature of Burial Officer		64. Signature of Burial Officer		65. Signature of Burial Officer	
66. Signature of Burial Officer		67. Signature of Burial Officer		68. Signature of Burial Officer		69. Signature of Burial Officer		70. Signature of Burial Officer	
71. Signature of Burial Officer		72. Signature of Burial Officer		73. Signature of Burial Officer		74. Signature of Burial Officer		75. Signature of Burial Officer	
76. Signature of Burial Officer		77. Signature of Burial Officer		78. Signature of Burial Officer		79. Signature of Burial Officer		80. Signature of Burial Officer	
81. Signature of Burial Officer		82. Signature of Burial Officer		83. Signature of Burial Officer		84. Signature of Burial Officer		85. Signature of Burial Officer	
86. Signature of Burial Officer		87. Signature of Burial Officer		88. Signature of Burial Officer		89. Signature of Burial Officer		90. Signature of Burial Officer	
91. Signature of Burial Officer		92. Signature of Burial Officer		93. Signature of Burial Officer		94. Signature of Burial Officer		95. Signature of Burial Officer	
96. Signature of Burial Officer		97. Signature of Burial Officer		98. Signature of Burial Officer		99. Signature of Burial Officer		100. Signature of Burial Officer	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6435
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06399

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 105 DAYS			
d. NAME OF HOSPITAL (If not hospital, give address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARVEY Middle ELMER Last DEVORE				4. DATE OF DEATH Month JUNE Day 4 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 14, 1893	
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mach. Helper				10b. KIND OF BUSINESS OR INDUSTRY Railroad			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THOMAS J. DEVORE				14. MOTHER'S MAIDEN NAME Rachael CLITES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X DUE TO Cerebral Vascular Accident Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cerebrovascular Disease (c) Diebels Mellitus							INTERVAL BETWEEN ONSET AND DEATH 105 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diebels Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 60 to June 19 60 , that (I) (we) last saw the deceased alive on June 4 19 60 and that death occurred 7:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. G. Overton Himmelwright				22b. DATE SIGNED 6/6/60			
22c. PHYSICIAN'S NAME (Type) Dr. G. Overton Himmelwright				22d. ADDRESS 133 Virginia Ave, Cumberland, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		23d. LOCATION (City, town, or county) (State) Fords Hill, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS 202 Greene St. Cumberland, Md.				25a. REC'D BY REGISTRAR JUN 9 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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FBI - NEW YORK

ALLEGEDLY

CONSPIRACY

REXELIUS KOSCHITZ

2000 1/2 AVENUE N.Y.C.

HARVEY KARPIS

DEVORE

1 AUGUST 1953

WHITE

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JUL 11 1953
FBI - NEW YORK

THOMAS J. DEVORE

RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6436

06400

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 7/I/59			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS Douglas Ave.			
3. NAME OF DECEASED (Type or print) First Hattie Middle Mae Last Dilfer				4. DATE OF DEATH Month 6 Day 13 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/30/1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Miller				14. MOTHER'S MAIDEN NAME Martha Raley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO 59.2X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Nephritis				INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration & psychosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Lonaconing				20g. (County) Allegany			
20h. (State) Md.							
21. I certify that (I) (this hospital) attended the deceased from 7/I/59 19, to 6/II/60 19, that (I) (we) last saw the deceased alive on 6/II/60 19, and that death occurred 12:25 from 11 causes and on the date stated above.							
22a. SIGNATURE James E. McLean				22b. DATE SIGNED 6-13-60		22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22d. ADDRESS 49 Greene St., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/15/1960		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONA CONING, MD.		25a. REC'D. BY REGISTRAR JUN 16 60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6489

CERTIFICATE OF DEATH

06401

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICK Middle ALPHONSUS Last FANNON		4. DATE OF DEATH Month JUNE Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 17, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY QUEEN CITY CANDY CO. MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD FANNON		14. MOTHER'S MAIDEN NAME ELLEN CUNNINGHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-26-9644	
17. INFORMANT MRS. CATHERINE FANNON, MT. SAVAGE, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Cardiac arrest 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary sclerosis (c) age		INTERVAL BETWEEN ONSET AND DEATH 30 min 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-20 1960 at 11 P.M. that (I) (we) last saw the deceased alive on 6-20 1960 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Otto Vogel, M.D.		22b. DATE 6-21-1960	
22c. PHYSICIAN'S NAME (Type) Otto Vogel, M.D.		22d. ADDRESS Main Str., Mt Save, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-23-60	
23c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d. LOCATION (City, town, or county) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. L. Durst,		25a. REC'D BY REGISTRAR FROSTBURG, MD.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE JUN 22 '60	

VR A1S (4)
ISM 9/59

6437

06402

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ALLEGANY		CUMBERLAND		4 days		SACRED HEART HOSPITAL			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
MARY		L		FEIGHT		6		17 19 60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
FEMALE		WHITE				8/1/72		87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Ownhome		MARYLAND Westernport		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
GILBERT KIGHT		SUSAN ADAMS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		none		CHART					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Hodgkins Disease				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-13-1960, to 6-17-1960 that (I) (we) last saw the deceased alive on 6-17-1960, and that death occurred at 8:15 A.M. from the causes and on the date stated above.									
22a. SIGNATURE DR. EARL PAUL		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
		36 GREENE STREET							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
Burial		6-20-1960		Philos Cemetery		Westernport, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli		Cumberland, Md.		JUN 21 '60		Arthur L. Hanks			

05101

CERTIFICATE OF DEATH

05101



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06403

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		b. COUNTY	
Allegany		Maryland		Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Big Savage Mountain		X		Big Savage Mountain	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3 Miles west of Frostburg, Maryland		3 Miles west of Frostburg, Maryland			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
GEORGE W GARLICK		June 20 19 60			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farmer		Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
Michael Garlick		Margaret Cease		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
215-10-1299		Mrs. Margaret Garlick		Barrellsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Coronary Occlusion, left		Sudden	
420.1		DUE TO		---	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary Sclerosis			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE James H. Fenster		M.D.		6-21-60	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
James H. Fenster Jr		Address (Street, city, town, or county)			
22b. BURIAL, CREMATION, REMOVAL (Specify)		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		Cooks Cemetery		Wellersburg, Maryland	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Ruth E. Silcox		Cumberland Maryland		June 27 1960	

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2000 BY 60322
UCBAW/STP

Alimony

Mr. George Kountz

1110 West of Riverside, Maryland

Mr. George Kountz

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Nov 2, 1902

Nov 2, 1902

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11-10-1902 Mrs. George Kountz

George Kountz, left

George Kountz

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George Kountz

may be filled in by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6482 CERTIFICATE OF DEATH

06404

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 50 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 Frost Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anne Middle C. Last Garrett		4. DATE OF DEATH Month June Day 16th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12th, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 16 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi T. DeWitt		14. MOTHER'S MAIDEN NAME Rosamond Kennedy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Marion Sloan, Cumberland, Md.		Address The Dingle,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of 197.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 197.2 DUE TO (c) 197.2 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 23, 1960 to JUNE 16, 1960 that (I) (we) last saw the deceased alive on JUNE 16, 1960 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein, M.D.		22b. DATE SIGNED 6/17/60	
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein,		22d. ADDRESS 48 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-60	
23c. NAME OF CEMETERY OR CREMATORY F'b.g. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Durrant		25a. REC'D BY REGISTRAR DATE JUN 20 '60	
ADDRESS Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6438

CERTIFICATE OF DEATH

Reg. Dist. No.

06405

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>505 Greene Street</u>			
3. NAME OF DECEASED (Type or print) <u>EDWARD</u> First <u>L.</u> Middle <u>GATES</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1879</u>		9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Gates</u>				14. MOTHER'S MAIDEN NAME <u>Maude Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217 14 4029</u>		17. INFORMANT <u>Robert Gates</u>		Address <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>NEPHROSCLEROSIS = ARTERIOSCLEROSIS</u> and (c) <u>and PROSTATIC OBSTRUCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 months</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Failure</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL-EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19, 1959</u> , to <u>June 30, 1960</u> ; that I last saw the deceased alive on <u>June 29, 1960</u> , and that death occurred at <u>1205 M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. G. WEISMAN</u> M.D.				ADDRESS (Street, city or town, state) <u>59 GREENE ST</u>		DATE SIGNED <u>7/1/60</u>	
PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN</u>				<u>CUMBERLAND, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06406

6439

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 328 Davidson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLOUGHBY Middle H. Last GAYHART				4. DATE OF DEATH Month June Day 26 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1895		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6 Days 5	IF UNDER 24 HRS. Hours 12 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Gayhart				14. MOTHER'S MAIDEN NAME Martha Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 139 09 20638		17. INFORMANT Mrs. Clara Gayhart Address Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMORRHAGE, MASSIVE DUE TO (b) SKULL FRACTURE DUE TO (c) SKULL FRACTURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 12 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on Street, 19 E. Laing Ave. Cumberland, Md.					
20c. TIME OF INJURY Month, Day, Year 6:00 p.m. June 25 19 60		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 26, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUN 28 '60 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

438

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle E Last HAINES		4. DATE OF DEATH Month JUNE Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 74 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) Higginsville, W.Va.		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME James H. Haines		15. MOTHER'S MAIDEN NAME Margaret Foltz	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS; PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY ARTERY DISEASE DUE TO (c) FRACTURE OF FIFTH RIB, RIGHT		INTERVAL BETWEEN ONSET AND DEATH 8 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF FIFTH RIB, RIGHT		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME	
20c. TIME OF INJURY Month, Day, Year 11:30 a.m. - JUNE 2 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) CUMBERLAND, ALLEG. MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED JUNE 8, 1960	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-60	
22c. NAME OF CEMETERY OR CREMATORY Allegany Co. Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md	
24a. REC'D BY REGISTRAR JUN 13 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

6496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, nr. Cumberland				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2, Williams Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RHODA ELIZABETH HARTLEY				4. DATE OF DEATH June 8 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1910	
9. AGE (In years lost birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Swift & Co.		11. BIRTHPLACE (State or foreign country) Bedford County, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Roberts				14. MOTHER'S MAIDEN NAME Eliza Bowden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-10-4867			
17. INFORMANT Route 2, Williams Road				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180x Neoplasm of the Adenocarcinoma of the stomach DUE TO (b) 4 months DUE TO (c) Interval between onset and death			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-5-60 to 6-8-60 that I last saw the deceased alive on 6-5-60 , and that death occurred at 11-19-60 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. Johnson M.D. 16 Greene Street, Cumberland, Md. 6-10-60				DATE SIGNED 6-10-60			
PHYSICIAN'S NAME (Type) James T. Johnson M.D. 16 Greene Street, Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1960		22c. NAME OF CEMETERY OR CREMATORY Herman Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR JUN 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0630

STATEMENT OF READING
CENTRAL OF TEXAS

1930



1

[Faint, illegible handwriting across the middle of the page]



John J. Butler, Ambassador, Kentucky

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06410

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b X Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS West Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle Hutchenson Last Hutchenson		4. DATE OF DEATH Month June Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Marshall		14. MOTHER'S MAIDEN NAME Margaret McKinley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Arch Hutchenson		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMORRHAGE DUE TO CONTUSIONS OF BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) "Son" (c) "		INTERVAL BETWEEN ONSET AND DEATH 3 Wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA, BILATERAL		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 900.6		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL DOWN THREE STEPS	
20c. TIME OF INJURY Month 3 Day 4 Year 1960 Hour 4:18 P.M. o. m. 3:40 P.M. p. m. 4:18 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> S.C. Murphy & Co.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) CUMBERLAND, ALLEG. MD.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED JUNE 4, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6442

CERTIFICATE OF DEATH

Item 8 Film G264 6/15/60 iwk

06411

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 15 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle A. Last HYMES		4. DATE OF DEATH Month JUNE Day 6 Year 1960		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1887 MARCH 6, 1887		9. AGE (In years lost birthday) yrs. 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME AUGUST HOUSER		14. MOTHER'S MAIDEN NAME CATHERINE TROLL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension arterio-sclerotic DUE TO (b) Cardiovascular disease DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Jan. 4/4		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1-4		20g. (County) 6-6-1960		20h. (State) 1960		21. I certify that (I) (this hospital) attended the deceased from 1-4 to 6-6-1960 that (I) met lost saw the deceased alive on 6-6-1960 and that death occurred at 3:58 P.M. the causes and on the date stated above.		22a. SIGNATURE W. F. Williams M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED 6-6-1960		22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-9-60	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) Cumberland, Md.		23e. (State) MD.		24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraw		25c. (City, town, or county) Cumberland, Md.		25d. (State) MD.		25e. (Country) U.S.A.		25f. (Other) 	



CERTIFICATE OF DEATH

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TIME

AGE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6497

CERTIFICATE OF DEATH

06412

1. PLACE OF DEATH a. COUNTY <u>Alleghany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W Va</u> b. COUNTY <u>Preston</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md, R. D. 5</u>		c. LENGTH OF STAY IN 1b <u>25 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Brailer</u> Last <u>Jefferys</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 24 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u> Hours <u>54</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keyser Ridge, M D</u>	
11. BIRTHPLACE (State or foreign country) <u>Keyser Ridge, M D</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>Ambrose Bra iler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Knecht</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Mrs Addeline Dunkinburg, Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of left breast</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 7 1</u> <u>54</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive + Arteriosclerotic Cardiovascular Renal Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15/8</u> to <u>June 23, 1960</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1960</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>S. G. WEISMAN</u>		22b. DATE <u>6/23/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN M.D.</u>		22d. ADDRESS <u>54 GREENE ST CUMBERLAND, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6- 27-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Joseph</u>		23d. LOCATION (City, town, or county) (State) <u>H owesville W Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Browning, Kingwood, W Va,</u>		25a. REC'D BY REGISTRAR DATE <u>6/25/60</u>	
25b. REGISTRAR'S SIGNATURE <u>Lucy A. Shaffer</u>		25c. DATE <u>6/25/60</u>	

CERTIFICATE OF DEATH

11330

11330

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Date of death: <i>10/15/1918</i></p>
<p>3. Place of death: <i>Home</i></p>		
<p>4. Cause of death: <i>Heart failure</i></p>		<p>5. Age at death: <i>45</i></p>
<p>6. Sex: <i>Male</i></p>		
<p>7. Occupation: <i>Farmer</i></p>		<p>8. Signature of physician: <i>[Signature]</i></p>
<p>9. Signature of registrar: <i>[Signature]</i></p>		
<p>10. Date of registration: <i>10/16/1918</i></p>		<p>11. Remarks: <i>[Blank]</i></p>
<p>12. Signature of informant: <i>[Signature]</i></p>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6443

CERTIFICATE OF DEATH

06413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>241 New Hampshire Ave.</u>		d. STREET ADDRESS <u>107 Luteman Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CRATES S. JOHNSON</u>		4. DATE OF DEATH Month Day Year <u>June 17 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ministry</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cyrus Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ballard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. N. O. Scribner, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> 420.11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1953</u> , to <u>June 17, 1960</u> , that I last saw the deceased alive on <u>June 15, 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Denge M. Brown</u> M.D. <u>Allegany Hotel</u> <u>6/17/60</u> PHYSICIAN'S NAME (Type) <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>June 21, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kiser</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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6444

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06414

1. PLACE OF DEATH o. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVENUE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY d. STREET ADDRESS RT. #1, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARRIE Middle V. Last KENNEY				4. DATE OF DEATH Month JUNE Day 14 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 27, 1908	
9. AGE (In years lost birthday) 52 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ridgeley, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HANSON SENN		14. MOTHER'S MAIDEN NAME SOPHIE ABE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral Hemorrhage with rt. hemiplegia DUE TO (b) Hypertensive and arteriosclerotic DUE TO (c) vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 June 1960 to 14 June 1960 , that (I) (we) last saw the deceased alive on 13 June 1960 , and that death occurred on 14 June 1960 at 3:45 AM from the causes and on the date stated above.							
22a. SIGNATURE W. Alfred Van Ormer M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER, 122 S. CENTRE ST.				22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JUN 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARITAL STATUS
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARITAL STATUS
DATE OF BIRTH
PLACE OF BIRTH

SIGNATURE OF REGISTRAR
SIGNATURE OF WITNESS
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
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OCCUPATION
MARITAL STATUS
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
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CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARITAL STATUS
DATE OF BIRTH
PLACE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6492
CERTIFICATE OF DEATH
06415

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b 33 yr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Greene St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport d. STREET ADDRESS 106 Greene St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Matilda Middle Lambert Last Lambert		4. DATE OF DEATH Month June Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Franklin, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Halterman		14. MOTHER'S MAIDEN NAME Arbelin Simmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Oscar Lambert, 106 Greene St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 Days 10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 13, 1960 to June 21, 1960 , that (I) (we) last saw the deceased alive on June 21, 1960 , and that death occurred at 8 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson M.D.		22b. DATE SIGNED June 22, 1960	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson, M.D.		22d. ADDRESS 11 Ashfield St. Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, '60	
23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City, town, or county) Westernport, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Baul ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

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1

CERTIFICATE OF DEATH

4432

State of New York
County of New York
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 10th day of June, 1922, at the City of New York, I attended the body of
Name of Deceased
who died at the residence of the deceased, at the City of New York, at the age of 45 years, of the disease of
Cause of Death
which was caused by
Influenza
and I am satisfied that the death was caused by the above disease.

Witness my hand and the seal of my office this 10th day of June, 1922.
Signature of Physician
My Commission Expires on the 1st day of June, 1923.
Signature of Registrar
Filed for Record this 10th day of June, 1922.
Signature of Registrar
Attest:
Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6445

CERTIFICATE OF DEATH

06416

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 02 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 311 Franklin Street			d. STREET ADDRESS 311 Franklin Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ASA First WILLIAM Middle LEWIS Last			4. DATE OF DEATH June Month 27 Day 60 Year 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1880		9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brewery Wkr		10b. KIND OF BUSINESS OR INDUSTRY Cumberland Brewery		11. BIRTHPLACE (State or foreign country) Near Kifer, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Asa Lewis			14. MOTHER'S MAIDEN NAME Elizabeth Moreland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 311 Franklin Street		
17. INFORMANT Mrs. Rosa Lewis			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c) Arterio-sclerosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 days		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 26 June 1960 to 26 June 1960 , that (I) (we) last saw the deceased alive on 26 June 1960 and that death occurred at 10 PM , from the causes and on the date stated above.					
22a. SIGNATURE David T. Rees			22b. DATE SIGNED 6/29/60		
22c. PHYSICIAN'S NAME (Type) David T. Rees M.D.			22d. ADDRESS 702 Montgomery Ave, Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION (City, town, or county) Cumberland, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			25a. REC'D BY REGISTRAR JUL 6 '60		
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06417

Reg. Dist. No.

6446

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN lb #3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS CRESAPTOWN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle LIMBERT Last LIMBERT				4. DATE OF DEATH Month June Day 10 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/23/02	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ENGLAND, Derby				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME GEORGE LIMBERT				14. MOTHER'S MAIDEN NAME ALICE ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach (primary site) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 Months 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/60		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafe. Cumberland, Md</i>				24a. REC'D BY REGISTRAR JUN 13 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2004

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06418

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		
c. LENGTH OF STAY IN 1b 10 days			d. STREET ADDRESS 230 Avirett Ave.,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hosp.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Paul Middle Last Lohof			4. DATE OF DEATH Month June Day 28, Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1898		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking lot Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Parking lot	11. BIRTHPLACE (State or foreign country) Amsterdam, Holland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Lohof			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 151-09-3281	17. INFORMANT Mrs. Edna Lohof Address 230 Avirett Ave., Cumb. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cranial hemorrhage DUE TO Skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 900.0 DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell down steps at residence					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps at residence			
20c. TIME OF INJURY Hour 1:30 o. m. 6/19/60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cumberland (County) Allegany (State) Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/29/60	
EXAMINER'S NAME (Type) Benedict Skitarelic M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/1/60	22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		22d. LOCATION (City, town, or county) Hyndman, Penna. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUL 5 '60
					24b. REGISTRAR'S SIGNATURE <i>James A. ...</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6448 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hosp.		d. STREET ADDRESS 22 McKenzie Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle RUSSELL Last LONG		4. DATE OF DEATH Month June Day 7 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1906
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acetate Dept. worker		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. Cumberland, Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Long		14. MOTHER'S MAIDEN NAME Virginia Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 217-10-6070	
17. INFORMANT Mrs. Minnie H. Long		Address La Vale, Md. 22 McKenzie Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis with thrombosis DUE TO (c) ----		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED JUNE 7, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/60	
22c. NAME OF CEMETERY OR CREMATORY Mount Herman Cem./		22d. LOCATION (City, town, or county) (State) Nr. Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Rouse	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. DATE OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. CAUSE OF DEATH</p>		<p>11. MANNER OF DEATH</p>		<p>12. SIGNATURE OF MEDICAL EXAMINER</p>	
<p>13. SIGNATURE OF NEXT OF KIN</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JURY</p>	
<p>21. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>22. SIGNATURE OF COUNTY ATTORNEY</p>		<p>23. SIGNATURE OF STATE ATTORNEY</p>		<p>24. SIGNATURE OF U.S. ATTORNEY</p>	
<p>25. SIGNATURE OF FEDERAL JUDGE</p>		<p>26. SIGNATURE OF FEDERAL CLERK</p>		<p>27. SIGNATURE OF FEDERAL SHERIFF</p>		<p>28. SIGNATURE OF FEDERAL CORONER</p>	
<p>29. SIGNATURE OF FEDERAL JURY</p>		<p>30. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>31. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>32. SIGNATURE OF FEDERAL STATE ATTORNEY</p>	
<p>33. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>34. SIGNATURE OF FEDERAL JUDGE</p>		<p>35. SIGNATURE OF FEDERAL CLERK</p>		<p>36. SIGNATURE OF FEDERAL SHERIFF</p>	
<p>37. SIGNATURE OF FEDERAL CORONER</p>		<p>38. SIGNATURE OF FEDERAL JURY</p>		<p>39. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>40. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>	
<p>41. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>42. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>43. SIGNATURE OF FEDERAL JUDGE</p>		<p>44. SIGNATURE OF FEDERAL CLERK</p>	
<p>45. SIGNATURE OF FEDERAL SHERIFF</p>		<p>46. SIGNATURE OF FEDERAL CORONER</p>		<p>47. SIGNATURE OF FEDERAL JURY</p>		<p>48. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>	
<p>49. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>50. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>51. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>52. SIGNATURE OF FEDERAL JUDGE</p>	
<p>53. SIGNATURE OF FEDERAL CLERK</p>		<p>54. SIGNATURE OF FEDERAL SHERIFF</p>		<p>55. SIGNATURE OF FEDERAL CORONER</p>		<p>56. SIGNATURE OF FEDERAL JURY</p>	
<p>57. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>58. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>59. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>60. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>	
<p>61. SIGNATURE OF FEDERAL JUDGE</p>		<p>62. SIGNATURE OF FEDERAL CLERK</p>		<p>63. SIGNATURE OF FEDERAL SHERIFF</p>		<p>64. SIGNATURE OF FEDERAL CORONER</p>	
<p>65. SIGNATURE OF FEDERAL JURY</p>		<p>66. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>67. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>68. SIGNATURE OF FEDERAL STATE ATTORNEY</p>	
<p>69. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>70. SIGNATURE OF FEDERAL JUDGE</p>		<p>71. SIGNATURE OF FEDERAL CLERK</p>		<p>72. SIGNATURE OF FEDERAL SHERIFF</p>	
<p>73. SIGNATURE OF FEDERAL CORONER</p>		<p>74. SIGNATURE OF FEDERAL JURY</p>		<p>75. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>76. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>	
<p>77. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>78. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>79. SIGNATURE OF FEDERAL JUDGE</p>		<p>80. SIGNATURE OF FEDERAL CLERK</p>	
<p>81. SIGNATURE OF FEDERAL SHERIFF</p>		<p>82. SIGNATURE OF FEDERAL CORONER</p>		<p>83. SIGNATURE OF FEDERAL JURY</p>		<p>84. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>	
<p>85. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>86. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>87. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>88. SIGNATURE OF FEDERAL JUDGE</p>	
<p>89. SIGNATURE OF FEDERAL CLERK</p>		<p>90. SIGNATURE OF FEDERAL SHERIFF</p>		<p>91. SIGNATURE OF FEDERAL CORONER</p>		<p>92. SIGNATURE OF FEDERAL JURY</p>	
<p>93. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>94. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>95. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>96. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>	
<p>97. SIGNATURE OF FEDERAL JUDGE</p>		<p>98. SIGNATURE OF FEDERAL CLERK</p>		<p>99. SIGNATURE OF FEDERAL SHERIFF</p>		<p>100. SIGNATURE OF FEDERAL CORONER</p>	
<p>101. SIGNATURE OF FEDERAL JURY</p>		<p>102. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>103. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>104. SIGNATURE OF FEDERAL STATE ATTORNEY</p>	
<p>105. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>106. SIGNATURE OF FEDERAL JUDGE</p>		<p>107. SIGNATURE OF FEDERAL CLERK</p>		<p>108. SIGNATURE OF FEDERAL SHERIFF</p>	
<p>109. SIGNATURE OF FEDERAL CORONER</p>		<p>110. SIGNATURE OF FEDERAL JURY</p>		<p>111. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>112. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>	
<p>113. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>114. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>115. SIGNATURE OF FEDERAL JUDGE</p>		<p>116. SIGNATURE OF FEDERAL CLERK</p>	
<p>117. SIGNATURE OF FEDERAL SHERIFF</p>		<p>118. SIGNATURE OF FEDERAL CORONER</p>		<p>119. SIGNATURE OF FEDERAL JURY</p>		<p>120. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>	
<p>121. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>122. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>123. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>124. SIGNATURE OF FEDERAL JUDGE</p>	
<p>125. SIGNATURE OF FEDERAL CLERK</p>		<p>126. SIGNATURE OF FEDERAL SHERIFF</p>		<p>127. SIGNATURE OF FEDERAL CORONER</p>		<p>128. SIGNATURE OF FEDERAL JURY</p>	
<p>129. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>130. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>131. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>132. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>	
<p>133. SIGNATURE OF FEDERAL JUDGE</p>		<p>134. SIGNATURE OF FEDERAL CLERK</p>		<p>135. SIGNATURE OF FEDERAL SHERIFF</p>		<p>136. SIGNATURE OF FEDERAL CORONER</p>	
<p>137. SIGNATURE OF FEDERAL JURY</p>		<p>138. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>139. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>140. SIGNATURE OF FEDERAL STATE ATTORNEY</p>	
<p>141. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>142. SIGNATURE OF FEDERAL JUDGE</p>		<p>143. SIGNATURE OF FEDERAL CLERK</p>		<p>144. SIGNATURE OF FEDERAL SHERIFF</p>	
<p>145. SIGNATURE OF FEDERAL CORONER</p>		<p>146. SIGNATURE OF FEDERAL JURY</p>		<p>147. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>148. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>	
<p>149. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>150. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>151. SIGNATURE OF FEDERAL JUDGE</p>		<p>152. SIGNATURE OF FEDERAL CLERK</p>	
<p>153. SIGNATURE OF FEDERAL SHERIFF</p>		<p>154. SIGNATURE OF FEDERAL CORONER</p>		<p>155. SIGNATURE OF FEDERAL JURY</p>		<p>156. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>	
<p>157. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>158. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>159. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>160. SIGNATURE OF FEDERAL JUDGE</p>	
<p>161. SIGNATURE OF FEDERAL CLERK</p>		<p>162. SIGNATURE OF FEDERAL SHERIFF</p>		<p>163. SIGNATURE OF FEDERAL CORONER</p>		<p>164. SIGNATURE OF FEDERAL JURY</p>	
<p>165. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>166. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>167. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>168. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>	
<p>169. SIGNATURE OF FEDERAL JUDGE</p>		<p>170. SIGNATURE OF FEDERAL CLERK</p>		<p>171. SIGNATURE OF FEDERAL SHERIFF</p>		<p>172. SIGNATURE OF FEDERAL CORONER</p>	
<p>173. SIGNATURE OF FEDERAL JURY</p>		<p>174. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>175. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>176. SIGNATURE OF FEDERAL STATE ATTORNEY</p>	
<p>177. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>178. SIGNATURE OF FEDERAL JUDGE</p>		<p>179. SIGNATURE OF FEDERAL CLERK</p>		<p>180. SIGNATURE OF FEDERAL SHERIFF</p>	
<p>181. SIGNATURE OF FEDERAL CORONER</p>		<p>182. SIGNATURE OF FEDERAL JURY</p>		<p>183. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>		<p>184. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>	
<p>185. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>186. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>187. SIGNATURE OF FEDERAL JUDGE</p>		<p>188. SIGNATURE OF FEDERAL CLERK</p>	
<p>189. SIGNATURE OF FEDERAL SHERIFF</p>		<p>190. SIGNATURE OF FEDERAL CORONER</p>		<p>191. SIGNATURE OF FEDERAL JURY</p>		<p>192. SIGNATURE OF FEDERAL DISTRICT ATTORNEY</p>	
<p>193. SIGNATURE OF FEDERAL COUNTY ATTORNEY</p>		<p>194. SIGNATURE OF FEDERAL STATE ATTORNEY</p>		<p>195. SIGNATURE OF FEDERAL U.S. ATTORNEY</p>		<p>196. SIGNATURE OF FEDERAL JUDGE</p>	
<p>197. SIGNATURE OF FEDERAL CLERK</p>		<p>198. SIGNATURE OF FEDERAL SHERIFF</p>		<p>199. SIGNATURE OF FEDERAL CORONER</p>		<p>200. SIGNATURE OF FEDERAL JURY</p>	

6449

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>480 Baltimore Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRIETT SUSAN MARTIN</u>				4. DATE OF DEATH <u>JUNE 8</u> 7 19 60			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 9, 1893</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant Wkr</u>			
11. BIRTHPLACE (State or foreign country) <u>Greenridge, Alleg. Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Albert Twigg</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-30-9885</u>			
17. INFORMANT <u>Mr. Wm. C. Martin</u>				Address <u>480 Balt. Avenue, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Chronic Salvator Heart Disease</u> DUE TO <u>Diabetes mellitus</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. <u>260X</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>County</u> (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Michael L. Glick</u>				M.D. <u>126 North Smallwood St. Cumberland, Md</u>			
PHYSICIAN'S NAME (Type) <u>Michael L. Glick M.D.</u>				6/9/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Bedford County, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06421

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>				c. LENGTH OF STAY IN 1b <u>66 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>407 Spruce St.</u>				d. STREET ADDRESS <u>407 Spruce St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 25, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Corriganville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry W. Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Susan Ann Garey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>712-14-1656</u>		17. INFORMANT <u>Mrs. Mabel Matthews,</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolus</u> DUE TO <u>4-20-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 29, 1960</u> to <u>June 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 29, 1960</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul R. Wilson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 30, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>				22d. ADDRESS <u>111 Ashfield St. Piedmont, W. Va.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 2, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. B. Baul</u>				ADDRESS <u>Westernport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

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CONTINUATION OF REPORT

1943

10 Pages

Continuation of Report

Department of Health

None

June 24, 1943

June 24, 1943

For R. Wilson M.D.
1000 19th Street, N.W.
Washington, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06422

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Motel 8 Mi. East of Cumb. Rt. 40		d. STREET ADDRESS 206 Penna. Ave.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Archie Middle Albert Last McDonald		4. DATE OF DEATH Month June Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1904
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	11. BIRTHPLACE (State or foreign country) Romney, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Wesley H. McDonald		14. MOTHER'S MAIDEN NAME Georgia O'Scannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 219-03-8310	
17. INFORMANT Mrs. Elsie M. McDonald		Address Cumb. Md. 206 Penna. Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH Sudden ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 6/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/60	22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery
22d. LOCATION (City, town, or county) (State) Nr. Romney, W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. H...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6450

CERTIFICATE OF DEATH

06423

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. # 5 Cumberland,			
c. LENGTH OF STAY IN 1b 20 minutes				d. STREET ADDRESS Fairgo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gallitzen Leo McKenzie				4. DATE OF DEATH Month 6 Day 9 Year 19 60			
5. SEX Male		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1893	
9. AGE (In years lost birthday) 67		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Cresaptown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel McKenzie		14. MOTHER'S MAIDEN NAME Alice Winters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. # 1 217-10-7676		17. INFORMANT Mrs. Marie H. McKenzie Rt. # 5 Cumb. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from 4-22-1960 to 6-9-1960 , that (I) (we) last saw the deceased alive on 6-9-1960 , and that death occurred at 8 AM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. R.W. Ballin, M.D.				22b. DATE SIGNED 6-10-60			
22c. PHYSICIAN'S NAME (Type) DR. R.W. BALLIN				22d. ADDRESS 62 GREENE STREET			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/11/60		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUN 14 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1943



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6451 CERTIFICATE OF DEATH

06424

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 57 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1 ROUTE #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY ANTHONY Middle A. Last MC LUCKIE				4. DATE OF DEATH Month JUNE Day 18 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 20, 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY Dairy Farm		11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ANDREW MC LUCKIE				14. MOTHER'S MAIDEN NAME ALICE LARUE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-36-7184		17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X Carcinoma of Esophagus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3:16 P.M. 6-18-1960 that (I) (we) last saw the deceased alive on 6-18-1960 and that death occurred at 10:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W.F. Williams M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-20-60	
22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS				22d. ADDRESS Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 24 '60	
						25b. REGISTRAR'S SIGNATURE	

1005

CERTIFICATE OF DEATH

1005

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WILLIAM

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6252

CERTIFICATE OF DEATH

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Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to fading and bleed-through.

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6453

CERTIFICATE OF DEATH

06426

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paulet Middle Cathy Last MIGDOL				4. DATE OF DEATH Month JUNE Day 7 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 5, 1960	
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 1 Hours 24		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME MICHAEL MIGDOL				14. MOTHER'S MAIDEN NAME CATHREAN FUNK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 Prematurity 24 wks. DUE TO (b) Preterm Separation Placental DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 4:45 AM from the causes and on the date stated above.							
22a. SIGNATURE F. B. Whitworth				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) F. B. WHITWORTH				22d. ADDRESS 123 BEDFORD ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 8, 1960		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	
23d. LOCATION (City, town, or county) Hyndman, Pa.				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Harvey L. Leigh				ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE JUN 10 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. House							

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6453

101

NAME OF DECEASED: [REDACTED] SEX: [REDACTED] AGE: [REDACTED]

DATE OF DEATH: [REDACTED]

1519 YOUNG ROAD

DEATH PLACE: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF BIRTH: [REDACTED]

CERTIFIED BY: [REDACTED]

STATE OF MASSACHUSETTS

MICHAEL [REDACTED]

GENERAL HOSPITAL, QUINCY, MASSACHUSETTS

153 BROAD ST., QUINCY, MASS.

T. B. WHITWORTH

DATE OF BIRTH: [REDACTED]

[REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6483

CERTIFICATE OF DEATH

Reg. Dist. No. 06427

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS R.D. #1, Woodland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle D. Last MORGAN				4. DATE OF DEATH Month 6 Day 29 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/25		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Class Worker		10b. KIND OF BUSINESS OR INDUSTRY retired(illness)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David J. Morgan				14. MOTHER'S MAIDEN NAME Sylvia (Spencer) Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 220-16-5557		INFORMANT Address Frostburg, Md. Mrs. Oliver D. Morgan, R.D.#1, Woodland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Cardiac Defect DUE TO (c) Life						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 60 , to June 24 1960 and that death occurred at 8:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg Md DATE SIGNED June 30 1960							
ACTUAL SIGNATURE W O Mc Lane M.D.				DATE June 30 1960			
PHYSICIAN'S NAME (Type) W O Mc Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-60		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bulah H. Montague				24. RECEIVED BY REGISTRAR Hafer Funeral Home 23 E. Main, Frostburg, Md.		25. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

CERTIFICATE OF DEATH

100-100000

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through from the reverse side.

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06429

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Allegany		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Mt. Savage		Mt. Savage	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
New Row		New Row	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
James Joseph Mulligan		June 10th, 1960	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		May 21st, 1871	
9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
89 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Ret.-Carman		C&P R.R.Shops	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Thomas Mulligan		Bridget Farrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		712-16-6260	
17. INFORMANT		Address	
Carl Mulligan, Mt.Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Heart weakness:acute insufficiency 7 days	
(b)		General arteriosclerosis,coronary sclerosis 10 years	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Ri left lower lobe pneumonia. Ri-sided hemiplegia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-15-1960 to 6-10-1960, that (I) (we) last saw the deceased alive on 6-10-1960 and that death occurred at 7P.M. from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE	
Otto Vogel M.D.		6-11-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Otto Vogel M.D.		Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		6-13-60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
St.Patrick's Cemetery		Mt. Savage, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Frostburg, Md.		DATE JUN 13 '60	
		25b. REGISTRAR'S SIGNATURE	
		Arthur S. Kraus	

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COPIES OF THIS REPORT
ARE BEING FURNISHED TO
THE FOLLOWING AGENCIES
FOR THEIR INFORMATION
AND USE:

44-38861

MONTHLY REPORT OF DEATH

6-18

NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	Cause of Death	Occupation	Marital Status	Education	Religion	Signature	Remarks
John A. Smith	45	M	W	1-15-1900	6-10-1945	New York, N.Y.	New York, N.Y.	Heart Disease	Teacher	Married	High School	Catholic	John A. Smith	
James E. Jones	32	M	W	3-20-1913	6-12-1945	Illinois, U.S.A.	Illinois, U.S.A.	Accident	Farmer	Married	High School	Methodist	James E. Jones	
William H. Davis	58	M	W	8-10-1887	6-11-1945	Ohio, U.S.A.	Ohio, U.S.A.	Stroke	Engineer	Married	College	Presbyterian	William H. Davis	
Robert L. Brown	28	M	W	11-5-1917	6-13-1945	California, U.S.A.	California, U.S.A.	Auto Accident	Police Officer	Single	High School	Baptist	Robert L. Brown	
Elizabeth C. White	62	F	W	4-22-1883	6-14-1945	Massachusetts, U.S.A.	Massachusetts, U.S.A.	Old Age	Homemaker	Married	High School	Quaker	Elizabeth C. White	
Charles F. Green	41	M	W	7-18-1904	6-15-1945	Georgia, U.S.A.	Georgia, U.S.A.	Heart Disease	Merchant	Married	College	Episcopal	Charles F. Green	
Mary D. Black	35	F	W	9-3-1910	6-16-1945	Michigan, U.S.A.	Michigan, U.S.A.	Cancer	Nurse	Married	College	Anglican	Mary D. Black	
Thomas G. Hall	55	M	W	12-1-1890	6-17-1945	Virginia, U.S.A.	Virginia, U.S.A.	Stroke	Lawyer	Married	College	Anglican	Thomas G. Hall	
Patricia K. Young	25	F	W	5-12-1920	6-18-1945	Washington, D.C.	Washington, D.C.	Accident	Secretary	Single	High School	Catholic	Patricia K. Young	
Franklin J. Lee	48	M	W	10-25-1897	6-19-1945	North Carolina, U.S.A.	North Carolina, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin J. Lee	
Grace M. Taylor	60	F	W	2-14-1885	6-20-1945	South Carolina, U.S.A.	South Carolina, U.S.A.	Old Age	Homemaker	Married	High School	Episcopal	Grace M. Taylor	
Harold N. Baker	38	M	W	6-8-1907	6-21-1945	Minnesota, U.S.A.	Minnesota, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold N. Baker	
Virginia O. Clark	52	F	W	1-3-1893	6-22-1945	Mississippi, U.S.A.	Mississippi, U.S.A.	Stroke	Teacher	Married	High School	Baptist	Virginia O. Clark	
William P. Lewis	43	M	W	11-17-1902	6-23-1945	Alabama, U.S.A.	Alabama, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	William P. Lewis	
Elizabeth R. Walker	30	F	W	4-28-1915	6-24-1945	Arkansas, U.S.A.	Arkansas, U.S.A.	Cancer	Nurse	Married	College	Anglican	Elizabeth R. Walker	
Robert S. Hall	50	M	W	7-10-1895	6-25-1945	Louisiana, U.S.A.	Louisiana, U.S.A.	Stroke	Lawyer	Married	College	Catholic	Robert S. Hall	
Patricia T. King	27	F	W	9-15-1918	6-26-1945	Delaware, U.S.A.	Delaware, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia T. King	
Franklin U. Scott	46	M	W	12-20-1899	6-27-1945	Montgomery, Ala.	Montgomery, Ala.	Heart Disease	Farmer	Married	High School	Methodist	Franklin U. Scott	
Grace V. Adams	58	F	W	3-12-1887	6-28-1945	South Dakota, U.S.A.	South Dakota, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace V. Adams	
Harold W. Baker	39	M	W	8-25-1906	6-29-1945	Nebraska, U.S.A.	Nebraska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold W. Baker	
Virginia X. Clark	31	F	W	10-1-1914	6-30-1945	Kansas, U.S.A.	Kansas, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia X. Clark	
William Y. Lewis	49	M	W	1-18-1896	7-1-1945	Oklahoma, U.S.A.	Oklahoma, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William Y. Lewis	
Patricia Z. Walker	29	F	W	5-22-1916	7-2-1945	Idaho, U.S.A.	Idaho, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia Z. Walker	
Franklin A. King	47	M	W	11-3-1898	7-3-1945	Wyoming, U.S.A.	Wyoming, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin A. King	
Grace B. Adams	59	F	W	2-25-1886	7-4-1945	Colorado, U.S.A.	Colorado, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace B. Adams	
Harold C. Baker	40	M	W	9-10-1905	7-5-1945	Utah, U.S.A.	Utah, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold C. Baker	
Virginia D. Clark	32	F	W	11-27-1913	7-6-1945	Nevada, U.S.A.	Nevada, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia D. Clark	
William E. Lewis	51	M	W	4-14-1894	7-7-1945	Arizona, U.S.A.	Arizona, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William E. Lewis	
Patricia F. Walker	28	F	W	6-19-1917	7-8-1945	New Mexico, U.S.A.	New Mexico, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia F. Walker	
Franklin G. King	48	M	W	12-11-1897	7-9-1945	California, U.S.A.	California, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin G. King	
Grace H. Adams	57	F	W	3-28-1888	7-10-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace H. Adams	
Harold I. Baker	41	M	W	8-1-1904	7-11-1945	Hawaii, U.S.A.	Hawaii, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold I. Baker	
Virginia J. Clark	33	F	W	10-24-1912	7-12-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia J. Clark	
William K. Lewis	52	M	W	1-22-1893	7-13-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William K. Lewis	
Patricia L. Walker	30	F	W	5-17-1915	7-14-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia L. Walker	
Franklin M. King	49	M	W	11-29-1896	7-15-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin M. King	
Grace N. Adams	60	F	W	2-19-1885	7-16-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace N. Adams	
Harold O. Baker	42	M	W	9-24-1903	7-17-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold O. Baker	
Virginia P. Clark	34	F	W	12-1-1911	7-18-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia P. Clark	
William Q. Lewis	53	M	W	4-27-1892	7-19-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William Q. Lewis	
Patricia R. Walker	31	F	W	6-22-1914	7-20-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia R. Walker	
Franklin S. King	50	M	W	12-13-1895	7-21-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin S. King	
Grace T. Adams	61	F	W	3-30-1884	7-22-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace T. Adams	
Harold U. Baker	43	M	W	9-26-1902	7-23-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold U. Baker	
Virginia V. Clark	35	F	W	11-2-1910	7-24-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia V. Clark	
William W. Lewis	54	M	W	1-29-1891	7-25-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William W. Lewis	
Patricia X. Walker	32	F	W	7-27-1913	7-26-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia X. Walker	
Franklin Y. King	51	M	W	12-24-1894	7-27-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin Y. King	
Grace Z. Adams	62	F	W	4-1-1883	7-28-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace Z. Adams	
Harold A. Baker	44	M	W	10-1-1901	7-29-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold A. Baker	
Virginia B. Clark	36	F	W	1-24-1909	7-30-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia B. Clark	
William C. Lewis	55	M	W	5-1-1890	7-31-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William C. Lewis	
Patricia D. Walker	33	F	W	8-2-1912	8-1-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia D. Walker	
Franklin E. King	52	M	W	12-25-1893	8-2-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin E. King	
Grace F. Adams	63	F	W	5-4-1882	8-3-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace F. Adams	
Harold G. Baker	45	M	W	10-2-1900	8-4-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold G. Baker	
Virginia H. Clark	37	F	W	2-1-1908	8-5-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia H. Clark	
William I. Lewis	56	M	W	6-3-1889	8-6-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William I. Lewis	
Patricia J. Walker	34	F	W	9-3-1911	8-7-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia J. Walker	
Franklin K. King	53	M	W	12-26-1892	8-8-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin K. King	
Grace L. Adams	64	F	W	6-5-1881	8-9-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace L. Adams	
Harold M. Baker	46	M	W	10-3-1899	8-10-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold M. Baker	
Virginia N. Clark	38	F	W	3-2-1907	8-11-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia N. Clark	
William O. Lewis	57	M	W	7-4-1888	8-12-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William O. Lewis	
Patricia P. Walker	35	F	W	10-4-1910	8-13-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia P. Walker	
Franklin Q. King	54	M	W	12-27-1891	8-14-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin Q. King	
Grace R. Adams	65	F	W	7-6-1880	8-15-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace R. Adams	
Harold S. Baker	47	M	W	10-4-1898	8-16-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold S. Baker	
Virginia T. Clark	39	F	W	4-3-1906	8-17-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia T. Clark	
William U. Lewis	58	M	W	8-5-1887	8-18-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William U. Lewis	
Patricia V. Walker	36	F	W	11-5-1909	8-19-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia V. Walker	
Franklin W. King	55	M	W	12-28-1890	8-20-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin W. King	
Grace X. Adams	66	F	W	8-7-1879	8-21-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace X. Adams	
Harold Y. Baker	48	M	W	10-5-1897	8-22-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold Y. Baker	
Virginia Z. Clark	40	F	W	5-6-1905	8-23-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia Z. Clark	
William A. Lewis	59	M	W	9-7-1886	8-24-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William A. Lewis	
Patricia B. Walker	37	F	W	12-7-1908	8-25-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia B. Walker	
Franklin C. King	56	M	W	1-8-1889	8-26-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin C. King	
Grace D. Adams	67	F	W	9-8-1878	8-27-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace D. Adams	
Harold E. Baker	49	M	W	10-6-1896	8-28-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold E. Baker	
Virginia F. Clark	41	F	W	6-8-1904	8-29-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia F. Clark	
William G. Lewis	60	M	W	10-8-1885	8-30-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William G. Lewis	
Patricia H. Walker	38	F	W	1-9-1907	8-31-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia H. Walker	
Franklin I. King	57	M	W	12-9-1888	9-1-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin I. King	
Grace J. Adams	68	F	W	10-9-1877	9-2-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace J. Adams	
Harold K. Baker	50	M	W	10-7-1895	9-3-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold K. Baker	
Virginia L. Clark	42	F	W	7-9-1903	9-4-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia L. Clark	
William M. Lewis	61	M	W	10-9-1884	9-5-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William M. Lewis	
Patricia N. Walker	39	F	W	2-10-1906	9-6-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Secretary	Single	High School	Episcopal	Patricia N. Walker	
Franklin O. King	58	M	W	1-10-1887	9-7-1945	Alaska, U.S.A.	Alaska, U.S.A.	Heart Disease	Farmer	Married	High School	Methodist	Franklin O. King	
Grace P. Adams	69	F	W	11-10-1876	9-8-1945	Alaska, U.S.A.	Alaska, U.S.A.	Old Age	Homemaker	Married	High School	Baptist	Grace P. Adams	
Harold Q. Baker	51	M	W	10-8-1894	9-9-1945	Alaska, U.S.A.	Alaska, U.S.A.	Accident	Engineer	Married	College	Lutheran	Harold Q. Baker	
Virginia R. Clark	43	F	W	8-11-1902	9-10-1945	Alaska, U.S.A.	Alaska, U.S.A.	Cancer	Nurse	Married	College	Anglican	Virginia R. Clark	
William S. Lewis	62	M	W	11-11-1883	9-11-1945	Alaska, U.S.A.	Alaska, U.S.A.	Stroke	Lawyer	Married	College	Catholic	William S. Lewis</	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6454

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06430
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>441 N. Centre St.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corriganville</u>	
3. NAME OF DECEASED (Type or print) First <u>CECIL</u> Middle <u>H.</u> Last <u>MYERS</u>		d. STREET ADDRESS <u>1</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23, 1914</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>60</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retail grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Eckhart, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Myers</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Rephann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 16 4440</u>	
17. INFORMANT <u>Mrs. Hazel McCormick</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DORONARY OCCLUSION</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 9, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 20 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport			
f. STREET ADDRESS 139 Front				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEE Middle NASSER Last NASSER				4. DATE OF DEATH Month JUNE Day 6 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lebanon	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Raphael				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Louis Nasser-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) 904-0 (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF RIGHT HIP							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL IN BATHROOM AT HOME			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7:00 May 19 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Westernport				(County) Alleg.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED JUNE 6, 1960			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) Westernport, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.A. Boal				24a. REC'D BY REGISTRAR JUN 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED MARY ANN ALLEN		SEX F		AGE 65	
DATE OF DEATH JULY 1, 1960		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME	
STREET ADDRESS 1234 E. BALTIMORE ST.		CITY BALTIMORE		STATE MARYLAND	
ZIP CODE 21201		COUNTY BALTIMORE		DISTRICT 1	
OCCUPATION RETIRED		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
MEDICAL HISTORY HYPERTENSION		PRESENT ILLNESS HEART ATTACK		SIGNS AND SYMPTOMS PAIN IN CHEST, SHORTNESS OF BREATH	
TREATMENT ASPIRIN, NITROGLYCERINE		POST-MORTEM EXAMINATION YES		ORGAN DONOR NO	
SIGNATURE OF EXAMINER DR. J. H. SMITH		SIGNATURE OF WITNESS MRS. J. H. SMITH		SIGNATURE OF DECEASED (None)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6456

06432

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTHER Middle --- Last NORTH				4. DATE OF DEATH Month June Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/3/77	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Black Valley, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,				10b. KIND OF BUSINESS OR INDUSTRY Own home			
13. FATHER'S NAME Martin LUTHER WILSON				14. MOTHER'S MAIDEN NAME EMILY BENNETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Martin Gordon Rt. # 1 Flintstone, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 DUE TO Chronic Myocarditis with Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. generalized arteriosclerosis DUE TO 5 year (c) INTERVAL BETWEEN ONSET AND DEATH 3 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 5-23-1960 to 6-1-1960 that (I) (we) last saw the deceased alive on 5-23-1960 and that death occurred at 1960 , from the causes and on the date stated above.			
22a. SIGNATURE J. T. Johnson, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-2-60	
22c. PHYSICIAN'S NAME (Type) DR. J.T. JOHNSON				22d. ADDRESS 16 GREENE ST			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JUN 6 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

6458

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6457 **CERTIFICATE OF DEATH** **06433**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 106 Frederick Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Paul Last Paul		4. DATE OF DEATH Month June Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 18 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Florist		10b. KIND OF BUSINESS OR INDUSTRY Florist - Proprietor	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Paul		14. MOTHER'S MAIDEN NAME Margaret Minnick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO 593X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis, DUE TO Chronic Nephritis (c) Chronic Nephritis			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Massive rt. supradural hematoma			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15/58 19 to 6/18/60 19 , that (I) (we) last saw the deceased alive on 6/17/60 19 , and that death occurred at 8:40 PM M , from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 6/20/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		23d. LOCATION (City, town, or county) (State) Cumberland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		25a. REC'D BY REGISTRAR JUN 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

ALABAMA STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MONTGOMERY, ALABAMA

ALABAMA STATE DEPARTMENT OF HEALTH
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MONTGOMERY, ALABAMA
1913/50
100 Montross Street
MONTGOMERY, ALABAMA

ALABAMA STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MONTGOMERY, ALABAMA
1913/50
100 Montross Street
MONTGOMERY, ALABAMA
John A. Paul
Resident: Florio
White
11/18/50
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Yours truly,
John A. Paul
MONTGOMERY, ALABAMA
ALABAMA STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MONTGOMERY, ALABAMA

ALABAMA STATE DEPARTMENT OF HEALTH
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MONTGOMERY, ALABAMA
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11/18/50
61
Yours truly,
John A. Paul
MONTGOMERY, ALABAMA
ALABAMA STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MONTGOMERY, ALABAMA

may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6458

CERTIFICATE OF DEATH

06434

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 HRS. 15 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS STAR ROUTE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SHIRLEY Middle ANN Last PLATTER				4. DATE OF DEATH Month JUNE Day 4 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 14, 1960	
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months 3 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) MEYERSDALE, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME PEGGY JOYCE PLATTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 				16. SOCIAL SECURITY NO. 		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUB-ENDO CARDIAL Fibroelastosis 754.4 DUE TO with Cardiac Failure and dilatation heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrush				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) (County) (State) 							
21. I certify that (I) (this hospital) attended the deceased from June 3, 1960 to June 4, 1960 , that (I) (we) last saw the deceased alive on June 4, 1960 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE R.A. Reiter, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 	
22c. PHYSICIAN'S NAME (Type) DR. REITER				22d. ADDRESS 112 Bedford St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/5/60		23c. NAME OF CEMETERY OR CREMATORY Buttinger		23d. LOCATION (City, town, or county) (State) BUTTINGER GARRETT Co MD	
24. FUNERAL DIRECTOR'S SIGNATURE Don Truman - Grantsville, Md.				25a. REC'D BY REGISTRAR 		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6459 CERTIFICATE OF DEATH 06435

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 4/25/60			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Homer Last Price				4. DATE OF DEATH Month June Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH II/26/1902	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Barber				10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George H. Price				14. MOTHER'S MAIDEN NAME Grace Binnix			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-10-8847		17. INFORMANT Po. Box 599 Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage. DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis. DUE TO ? (c) Spastic paraplegia. 5 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 5 mos 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/25/60 19 to 6/11/60 19, that (I) (we) last saw the deceased alive on 6/11/60 19, and that death occurred 11:40 A.M. on the date stated above.							
22a. SIGNATURE James E. McLean				22b. DATE SIGNED 6-13-60			
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 15, 1960		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06456

6450

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Mary St				d. STREET ADDRESS 107 Mary Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Carl Last Pryor				4. DATE OF DEATH Month June Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 20, 1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62		IF UNDER 24 HRS. Hours 62 Min. 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinists Helper				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob A. Pryor				14. MOTHER'S MAIDEN NAME Susan Bridenthall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-5152		17. INFORMANT Michael H. Pryor Address Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED JUNE 2, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Prosperity Methodist Cem.		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc				ADDRESS 117 Frederick St. Cumb.		24a. REC'D BY REGISTRAR JUN 6 '60	
				24b. REGISTRAR'S SIGNATURE Carlton S. P. P.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. OCCUPATION Carpenter	
5. PLACE OF BIRTH Maryland		6. DATE OF BIRTH Jan 15, 1900		7. DATE OF DEATH Jan 20, 1940		8. TIME OF DEATH 10:30 AM	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. H. HARRIS	
13. SIGNATURE OF NEXT OF KIN J. H. HARRIS		14. SIGNATURE OF WITNESSES J. H. HARRIS		15. SIGNATURE OF CLERK J. H. HARRIS		16. SIGNATURE OF JURY J. H. HARRIS	
17. SIGNATURE OF MEDICAL EXAMINER J. H. HARRIS		18. SIGNATURE OF CLERK J. H. HARRIS		19. SIGNATURE OF JURY J. H. HARRIS		20. SIGNATURE OF DECEASED J. H. HARRIS	
21. SIGNATURE OF DECEASED J. H. HARRIS		22. SIGNATURE OF DECEASED J. H. HARRIS		23. SIGNATURE OF DECEASED J. H. HARRIS		24. SIGNATURE OF DECEASED J. H. HARRIS	
25. SIGNATURE OF DECEASED J. H. HARRIS		26. SIGNATURE OF DECEASED J. H. HARRIS		27. SIGNATURE OF DECEASED J. H. HARRIS		28. SIGNATURE OF DECEASED J. H. HARRIS	
29. SIGNATURE OF DECEASED J. H. HARRIS		30. SIGNATURE OF DECEASED J. H. HARRIS		31. SIGNATURE OF DECEASED J. H. HARRIS		32. SIGNATURE OF DECEASED J. H. HARRIS	
33. SIGNATURE OF DECEASED J. H. HARRIS		34. SIGNATURE OF DECEASED J. H. HARRIS		35. SIGNATURE OF DECEASED J. H. HARRIS		36. SIGNATURE OF DECEASED J. H. HARRIS	
37. SIGNATURE OF DECEASED J. H. HARRIS		38. SIGNATURE OF DECEASED J. H. HARRIS		39. SIGNATURE OF DECEASED J. H. HARRIS		40. SIGNATURE OF DECEASED J. H. HARRIS	
41. SIGNATURE OF DECEASED J. H. HARRIS		42. SIGNATURE OF DECEASED J. H. HARRIS		43. SIGNATURE OF DECEASED J. H. HARRIS		44. SIGNATURE OF DECEASED J. H. HARRIS	
45. SIGNATURE OF DECEASED J. H. HARRIS		46. SIGNATURE OF DECEASED J. H. HARRIS		47. SIGNATURE OF DECEASED J. H. HARRIS		48. SIGNATURE OF DECEASED J. H. HARRIS	
49. SIGNATURE OF DECEASED J. H. HARRIS		50. SIGNATURE OF DECEASED J. H. HARRIS		51. SIGNATURE OF DECEASED J. H. HARRIS		52. SIGNATURE OF DECEASED J. H. HARRIS	
53. SIGNATURE OF DECEASED J. H. HARRIS		54. SIGNATURE OF DECEASED J. H. HARRIS		55. SIGNATURE OF DECEASED J. H. HARRIS		56. SIGNATURE OF DECEASED J. H. HARRIS	
57. SIGNATURE OF DECEASED J. H. HARRIS		58. SIGNATURE OF DECEASED J. H. HARRIS		59. SIGNATURE OF DECEASED J. H. HARRIS		60. SIGNATURE OF DECEASED J. H. HARRIS	
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65. SIGNATURE OF DECEASED J. H. HARRIS		66. SIGNATURE OF DECEASED J. H. HARRIS		67. SIGNATURE OF DECEASED J. H. HARRIS		68. SIGNATURE OF DECEASED J. H. HARRIS	
69. SIGNATURE OF DECEASED J. H. HARRIS		70. SIGNATURE OF DECEASED J. H. HARRIS		71. SIGNATURE OF DECEASED J. H. HARRIS		72. SIGNATURE OF DECEASED J. H. HARRIS	
73. SIGNATURE OF DECEASED J. H. HARRIS		74. SIGNATURE OF DECEASED J. H. HARRIS		75. SIGNATURE OF DECEASED J. H. HARRIS		76. SIGNATURE OF DECEASED J. H. HARRIS	
77. SIGNATURE OF DECEASED J. H. HARRIS		78. SIGNATURE OF DECEASED J. H. HARRIS		79. SIGNATURE OF DECEASED J. H. HARRIS		80. SIGNATURE OF DECEASED J. H. HARRIS	
81. SIGNATURE OF DECEASED J. H. HARRIS		82. SIGNATURE OF DECEASED J. H. HARRIS		83. SIGNATURE OF DECEASED J. H. HARRIS		84. SIGNATURE OF DECEASED J. H. HARRIS	
85. SIGNATURE OF DECEASED J. H. HARRIS		86. SIGNATURE OF DECEASED J. H. HARRIS		87. SIGNATURE OF DECEASED J. H. HARRIS		88. SIGNATURE OF DECEASED J. H. HARRIS	
89. SIGNATURE OF DECEASED J. H. HARRIS		90. SIGNATURE OF DECEASED J. H. HARRIS		91. SIGNATURE OF DECEASED J. H. HARRIS		92. SIGNATURE OF DECEASED J. H. HARRIS	
93. SIGNATURE OF DECEASED J. H. HARRIS		94. SIGNATURE OF DECEASED J. H. HARRIS		95. SIGNATURE OF DECEASED J. H. HARRIS		96. SIGNATURE OF DECEASED J. H. HARRIS	
97. SIGNATURE OF DECEASED J. H. HARRIS		98. SIGNATURE OF DECEASED J. H. HARRIS		99. SIGNATURE OF DECEASED J. H. HARRIS		100. SIGNATURE OF DECEASED J. H. HARRIS	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6484

CERTIFICATE OF DEATH

06437

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b X Midland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle QUINN Last QUINN				4. DATE OF DEATH Month 6 Day 29 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/20/1878	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 8 Days 1 Hours 19		IF UNDER 24 HRS. Months 8 Days 1 Hours 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Quinn				14. MOTHER'S MAIDEN NAME Sarah Murry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Julia Quinn, Midland, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma transverse colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) (SISTER) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured left hip - Congestive heart failure				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1958 to June 22, 1960 that (I) (we) last saw the deceased alive on June 22, 1960 , and that death occurred at 11 AM , from the causes and on the date stated above.							
22a. SIGNATURE James Quinn				22b. DATE SIGNED June 22, 1960			
22c. PHYSICIAN'S NAME (Type) L.R. MILES JR., M.D.				22d. ADDRESS LONA CONING MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/2/1960		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.				25a. REC'D BY REGISTRAR DATE JUL 6 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

STATE OF OHIO
JUDICIAL DEPARTMENT
COURT OF COMMON PLEAS

Case No.

Plaintiff

vs.

Defendant

Witness

Witness

Subscribed and sworn to before me this _____ day of _____, 19____.

Notary Public

My Comm. Expires _____

Notary Public

Attest

My Comm. Expires _____

Notary Public

Witness

Witness

Witness

Witness

Witness

Witness

Witness

Witness

Witness

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Witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6461

CERTIFICATE OF DEATH

06438

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 450 Waverly Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle L. Last Ring		4. DATE OF DEATH Month June Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/3/1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 8 Days 2	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY For: Cumberland Steele Co. Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Ring		14. MOTHER'S MAIDEN NAME Elizabeth Gleichman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-8876A	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 3 ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/19/56 to 6/5/60 , that (I) (we) last saw the deceased alive on 6/4/60 , and that death occurred at 11:55 A.M.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 6-6-60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/9/60	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR JUN 10 '60	
ADDRESS Cumberland, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

1913



Allegany

Harford

Allegany

Cambridge

Allegany

Cambridge

Allegany County Jail

120 Waverly Terrace

John

King

June

52

1913

White

Notched-Machine Co., Cambridge, Maryland, U. S. A.

Ellen M. Johnson

Robert King

W. J. King, Jr., 120 Waverly Terrace, Cambridge, Md.
Witnesses: W. J. King, Jr., 120 Waverly Terrace, Cambridge, Md.
Witnesses: W. J. King, Jr., 120 Waverly Terrace, Cambridge, Md.



CHIEF

White

1913

U. S. Census Bureau, Washington, D. C.

U. S. Census Bureau, Washington, D. C.

U. S. Census Bureau, Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cumberland, (Rural)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hosp.				d. STREET ADDRESS R. D. # 3.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First RUSSELL Middle LUE Last ROBINETTE				4. DATE OF DEATH Month June Day 24 , Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/3/1910		
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder			10b. KIND OF BUSINESS OR INDUSTRY Welding Co.		11. BIRTHPLACE (State or foreign country) R. D. # 3 Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Olver Robinette				14. MOTHER'S MAIDEN NAME Alice Irons				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-07-6700		17. INFORMANT Address Mrs. Blanche Robinette Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Blast Injury DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 min. Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Explosion of tank truck				
20c. TIME OF INJURY Month, Day, Year 10:20 a. m. 6/24/ 1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage		20f. (City or town) (County) (State) Cumberland, Allegany Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 24, 1960				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/1960		22c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 27 '60		
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		10/15/1960	
Place of Death		Cause of Death		Manner of Death		Occupation		Residence	
Home		Heart Disease		Natural		Teacher		123 Main St.	
Physician		Hospital		Burial		Funeral Home		Cemetery	
Dr. Smith		St. Mary's		St. Mary's		Doe & Sons		Greenwood	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Funeral Director		Signature of Burial Director	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Signature of Medical Examiner		Signature of Coroner	
10/15/1960		10:00 AM		Home		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 31yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Street				d. STREET ADDRESS Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle J Last ROONEY				4. DATE OF DEATH Month 6 Day 4 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1928	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Employed		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Erostburg, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Rooney				14. MOTHER'S MAIDEN NAME Margaret Flynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-1965		17. INFORMANT Address Miss Mary Rooney, Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, LEFT DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 15-20 Min. ***	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		JUNE 4, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/60		22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE JUN 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6485
CERTIFICATE OF DEATH

06441

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b 70YRS.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 186 W. MAIN STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ROSARIA Middle (MARRO) Last RUFFO				4. DATE OF DEATH Month JUNE Day 24 , Year 1960					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 27, 1873			
9. AGE (In years lost birth day) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) CELICO, ITALY			
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME FRANK MARRO				14. MOTHER'S MAIDEN NAME ROSE TELLERICO					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE				16. SOCIAL SECURITY NO. NONE					
17. INFORMANT FRANK RUFFO,				Address FROSTBURG, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Cardiac arrest, heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized high degree of arteriosclerosis DUE TO incl. cerebral vessels (c) age								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) large decubital ulcer, ascending kidney-pelvis infection								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from December 15, 1960 to June 19, 1960 , that (I) (we) last saw the deceased alive on 6-22-60 19, and that death occurred at 2 AM from the causes and on the date stated above.									
22a. SIGNATURE OTTO VOGEL MD				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) OTTO VOGEL, M. D.				22d. ADDRESS MAIN ST., FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-27-60		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE J. K. Durst				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE JUN 28 '60			
						25b. REGISTRAR'S SIGNATURE Arthur S. House			

CERTIFICATE OF DEATH

1982

101

101

NAME	JOHN
DATE OF BIRTH	1900
PLACE OF BIRTH	NEW YORK
DATE OF DEATH	1982
PLACE OF DEATH	NEW YORK
CAUSE OF DEATH	HEART DISEASE
DATE OF BURIAL	1982
PLACE OF BURIAL	NEW YORK
NAME OF FUNERAL HOME	JOHN'S FUNERAL HOME
NAME OF MINISTER	JOHN'S MINISTER
NAME OF CLERGYMAN	JOHN'S CLERGYMAN
NAME OF CHURCH	JOHN'S CHURCH
NAME OF CEMETERY	JOHN'S CEMETERY
NAME OF BURIAL	JOHN'S BURIAL
NAME OF FUNERAL HOME	JOHN'S FUNERAL HOME
NAME OF MINISTER	JOHN'S MINISTER
NAME OF CLERGYMAN	JOHN'S CLERGYMAN
NAME OF CHURCH	JOHN'S CHURCH
NAME OF CEMETERY	JOHN'S CEMETERY
NAME OF BURIAL	JOHN'S BURIAL

NAME	JOHN
DATE OF BIRTH	1900
PLACE OF BIRTH	NEW YORK
DATE OF DEATH	1982
PLACE OF DEATH	NEW YORK
CAUSE OF DEATH	HEART DISEASE
DATE OF BURIAL	1982
PLACE OF BURIAL	NEW YORK
NAME OF FUNERAL HOME	JOHN'S FUNERAL HOME
NAME OF MINISTER	JOHN'S MINISTER
NAME OF CLERGYMAN	JOHN'S CLERGYMAN
NAME OF CHURCH	JOHN'S CHURCH
NAME OF CEMETERY	JOHN'S CEMETERY
NAME OF BURIAL	JOHN'S BURIAL
NAME OF FUNERAL HOME	JOHN'S FUNERAL HOME
NAME OF MINISTER	JOHN'S MINISTER
NAME OF CLERGYMAN	JOHN'S CLERGYMAN
NAME OF CHURCH	JOHN'S CHURCH
NAME OF CEMETERY	JOHN'S CEMETERY
NAME OF BURIAL	JOHN'S BURIAL

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6463

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First A. Middle A. Last SCHURG		4. DATE OF DEATH Month JUNE Day 28 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 11, 1913		9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS WILLISON				14. MOTHER'S MAIDEN NAME LILLIE TWIGG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-07-6917		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 171X IMMEDIATE CAUSE (a) Asbestosis DUE TO Carcinoma of Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs +						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 60 to June 27 19 60 that (I) (we) last saw the deceased alive on June 27 19 60 and that death occurred at 3:45 AM from the causes and on the date stated above.							
22a. SIGNATURE Lewis Roauld				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. L. LEWIS MOULD	
22d. ADDRESS 122 SO. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-30-60		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION (City, town, or county) (State) Eckhart, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montecout				25a. REC'D BY REGISTRAR Hafer Funeral Home		25b. REGISTRAR'S SIGNATURE Arthur L. Haas	
25c. ADDRESS 23 E. Main, Frostburg, Md.				25d. DATE JUL 11 '60			



MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1913

REGISTERED

DECEASED

DECEASED

11 DAYS

DECEASED

GENERAL HOSPITAL
GENERAL & FURNITURE

CHURCH

MARY

DECEMBER 11, 1913

WHITE

MARY

DECEASED

DECEASED

WHITE

WHITE

GENERAL HOSPITAL, BOSTON, MASS.

Handwritten signature

DECEASED

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4½ HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle MABEL Last SHELLEY		4. DATE OF DEATH Month JUNE Day 8 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1891
9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) VIRGINIA, Berryville		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVIS RIGGLEMAN		14. MOTHER'S MAIDEN NAME PHEOBE C. EVERSOLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction (c) arteriosclerotic and hypertensive cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 June 60 10:30 A.M. , that (I) (we) last saw the deceased alive on 7 June 19 60 , and that death occurred at 3:30 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER		22d. ADDRESS 122 S. Central St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/60	
23c. NAME OF CEMETERY OR CREMATORY Rock Oak Cemetery		23d. LOCATION (City, town, or county) (State) Rock Oak, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR JUN 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

CERTIFICATE OF DEATH

LEGALLY

UNDERSTANDING

15 HOURS

LEGALLY

15 HOURS

120 GRAD AVE

GENERAL HOSPITAL

5

JUNE

SHILLY

1917

1917

1917

JULY 17, 1917

1917

1917

1917

1917

1917

1917

GENERAL HOSPITAL - UNDERSTANDING

GENERAL HOSPITAL - UNDERSTANDING

Handwritten notes in cursive script, likely a medical or legal record, covering the middle section of the page.

Handwritten signature or name at the bottom of the notes.

Handwritten text at the bottom of the page, possibly a date or reference number.

DR. W. VAN BUREN

Additional handwritten text at the very bottom of the page.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6465

06444

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DENNIS Middle LEE Last SIMONS				4. DATE OF DEATH Month JUNE Day 9 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-60	
9. AGE (In years lost birthday) 0 yrs.		IF UNDER 1 YEAR Months 2 Days 9		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD D. SIMONS				14. MOTHER'S MAIDEN NAME RRANCES CHRISTMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Richard D. Simons, Rt. # 3 Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561.5 DUE TO millitary obstruction in the bowel's digestive tract Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) strangled a hernia hydrocele DUE TO (c) operated on on 6/7/60 INTERVAL BETWEEN ONSET AND DEATH 2 weeks a few hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) congenital malformation of the heart, conduction system, aortic							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 6					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/6 to 6-9 , 19 60 that (I) (we) last saw the deceased alive on 19 and that death occurred at 1:10 PM , from the causes and on the date stated above.							
22a. SIGNATURE DR. E. BRINGS				22b. DATE SIGNED 6/10/60			
22c. PHYSICIAN'S NAME (Type) DR. E. BRINGS				22d. ADDRESS 55 Green St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/11/60		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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OFFICE OF THE
SHERIFF
COUNTY OF
LOS ANGELES
CALIFORNIA

DEPARTMENT OF
PUBLIC HEALTH

DEATH

DATE

TIME

PLACE

AGE

SEX

HUSBAND

WIFE

CHILD

OTHER

RELATIONSHIP

CAUSE

MANNER

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6466

06445

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEDFORD, (RURAL)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES				d. STREET ADDRESS ROUTE 3,			
3. NAME OF DECEASED (Type or print) First ANNA Middle V. Last SIMPSON				4. DATE OF DEATH Month JUNE Day 27 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 23, 1912		9. AGE (In years last birthday) 48		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MAYSVILLE, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OXO OCE MONGOLD				14. MOTHER'S MAIDEN NAME EMMA TURNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 416X IMMEDIATE CAUSE (a) Chronic Rheumatic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Since 1954						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6:25 19 59 to 6-27-60 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 6-26-60 and that death occurred at 12:20 AM on the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams M.D.				22b. DATE SIGNED 6-27-60		22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS	
22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 29, 1960		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JUN 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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CERTIFICATE OF DEATH

1962

1962

DEPARTMENT OF HEALTH		COUNTY OF	
CITY OF		STATE OF	
DECEASED (Full Name)		SEX	
AGE		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	

FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6467

Reg. Dist. No. 06446

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 Park St.,		d. STREET ADDRESS 109 Park St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Critchfield Last Skinner		4. DATE OF DEATH Month June Day 14 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	11. BIRTHPLACE (State or foreign country) Ohiopyle, Penna.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Abraham Skinner		14. MOTHER'S MAIDEN NAME Catherine Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 705-09-6122	
17. INFORMANT Mr. Randall Skinner, Connellsville, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO 429.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 4 - 28 , 19 60 , to 6 - 14 , 19 60 that I last saw the deceased alive on 6 - 14 , 19 60 , and that death occurred at 5:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St., DATE SIGNED 6 - 16-60 ACTUAL SIGNATURE Ralph W. Ballin M.D. PHYSICIAN'S NAME (Type) Ralph W. Ballin M. D. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/60	
22c. NAME OF CEMETERY OR CREMATORY Hickman Baptist Cem.		22d. LOCATION (City, town, or county) (State) Mill Run, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06447

6499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 50yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt#2 Williams Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alonzo Middle E. Last Snider		4. DATE OF DEATH Month June Day 21 , Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1869
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self emp.	
11. BIRTHPLACE (State or foreign country) Kingwood, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Snider		14. MOTHER'S MAIDEN NAME Susanna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug , 19 54 , to June , 19 60 , that I last saw the deceased alive on June 20 , 19 60 , and that death occurred at 1:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Overton Himmelwright M.D.		ADDRESS (Street, city or town, state) 133 Virginia Ave. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.
22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15 1912		Baltimore, Md.	
Cause of Death		Disease		Organ		Nature		Site	
Heart Disease		Coronary Artery Sclerosis		Heart		Narrowing of Arteries		Left Ventricle	
Immediate Cause		Disease		Organ		Nature		Site	
Myocardial Infarction		Coronary Artery Sclerosis		Heart		Narrowing of Arteries		Left Ventricle	
Contributing Cause		Disease		Organ		Nature		Site	
Hypertension		Kidneys		Kidneys		Narrowing of Arteries		Left Ventricle	
Occupation		Profession		Education		Marital Status		Religion	
Clerk		Clerk		High School		Married		Roman Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove organ papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06448

6468

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 7 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVENUE				d. STREET ADDRESS 33 VIRGINIA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HILDA Middle C. Last SPEARMAN				4. DATE OF DEATH Month JUNE Day 14 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 3, 1900	
				9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worship Knitting		10b. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW SPEARMAN				14. MOTHER'S MAIDEN NAME ROSE F. NEUSCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritic Nephrosis DUE TO Glomerular Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 7 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumpr. Alleg. Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/7/60 19____, that (I) (we) last saw the deceased alive on 6/13/60 19____, and that death occurred at 4:50 AM on the causes and on the date stated above.							
22a. SIGNATURE [Signature] M.D.				22b. DATE SIGNED 6/13/60			
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-60		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR JUN 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER
ALBANY, N. Y.

ALBANY, N. Y.

DECEMBER 1, 1901

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ALBANY, N. Y.

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DECEMBER 1, 1901

ALBANY, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. STREET ADDRESS BOX 11 ELLERSIE	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES JOSEPH SPEARMAN		4. DATE OF DEATH Month Day Year JUNE 26 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Insp. B & O Railroad		10b. KIND OF BUSINESS OR INDUSTRY PA. Pittsburgh	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH J. SPEARMAN		14. MOTHER'S MAIDEN NAME Alice MARY CLARK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW 1		16. SOCIAL SECURITY NO. 705-09-6682	
17. INFORMANT PTS. CHART.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 4-20-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hours 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-3 1960 to 6-26- 1960 , that (I) (we) last saw the deceased alive on 6-26 1960 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L. Brings		22b. DATE SIGNED 6/27/60	
22c. PHYSICIAN'S NAME (Type) Louis Brings, M.D.		22d. ADDRESS 576 Green St. Cumberland Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/29/60	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Catholic Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE JUN 30 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

2888



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6470
CERTIFICATE OF DEATH

Reg. Dist. No. 08450

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>166 Cresap Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>David R. Stallings</u>		4. DATE OF DEATH Month Day Year <u>June 29 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1882</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Masonry</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Stallings</u>		14. MOTHER'S MAIDEN NAME <u>Anna C. Twigg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. R.F. Van Horn</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 WKS</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-24</u> , 19 <u>60</u> to <u>6-29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-29</u> , 19 <u>60</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>William P. James</u> M.D. <u>4414 Antioch St.</u> <u>7-1-60</u>			
ACTUAL SIGNATURE <u>William P. James</u>			
PHYSICIAN'S NAME (Type) <u>William P. James</u> <u>Cumberland</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Herman Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stem</u>		ADDRESS <u>2nd Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. & H. H. H.</u>	

CERTIFICATE OF DEATH

1950

1. DECEASED'S NAME (Last, first, middle initial) <i>John William Smith</i>		2. SEX <i>Male</i>	
3. AGE (in years and months) <i>65 years, 10 months</i>		4. DATE OF BIRTH <i>March 15, 1884</i>	
5. PLACE OF BIRTH (City, State, Country) <i>Baltimore, Maryland, U.S.A.</i>		6. RACE <i>White</i>	
7. OCCUPATION <i>Retired</i>		8. MARITAL STATUS <i>Married</i>	
9. US BIRTHPLACE (City, State, Country) <i>Baltimore, Maryland, U.S.A.</i>		10. US CITIZENSHIP <i>Yes</i>	
11. DATE OF DEATH <i>April 10, 1950</i>		12. TIME OF DEATH <i>10:15 A.M.</i>	
13. PLACE OF DEATH (City, State, Country) <i>Baltimore, Maryland, U.S.A.</i>		14. CAUSE OF DEATH (Immediate cause) <i>Myocardial Infarction</i>	
15. UNDERLYING CAUSE OF DEATH (List all causes) <i>Myocardial Infarction</i>		16. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide) <i>Natural</i>	
17. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		18. SIGNATURE OF DEATH REGISTRAR <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	

1. DECEASED'S NAME (Last, first, middle initial)
2. SEX
3. AGE (in years and months)
4. DATE OF BIRTH
5. PLACE OF BIRTH (City, State, Country)
6. RACE
7. OCCUPATION
8. MARITAL STATUS
9. US BIRTHPLACE (City, State, Country)
10. US CITIZENSHIP
11. DATE OF DEATH
12. TIME OF DEATH
13. PLACE OF DEATH (City, State, Country)
14. CAUSE OF DEATH (Immediate cause)
15. UNDERLYING CAUSE OF DEATH (List all causes)
16. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide)
17. SIGNATURE OF PHYSICIAN
18. SIGNATURE OF DEATH REGISTRAR
19. SIGNATURE OF WITNESS
20. SIGNATURE OF WITNESS

may be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6486

06451

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 45 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Stark Last Stark				4. DATE OF DEATH Month June Day 2nd , Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25th, 1884	
9. AGE (In years lost birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Stark				14. MOTHER'S MAIDEN NAME Jean Robertson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-09-6544		17. INFORMANT Address 148 Maple St., Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency DUE TO chest pain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 24 hr DUE TO serial (c) years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24 hr							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 17 , 19 60 to June 2 , 19 60 , that (I) (we) last saw the deceased alive on June 2 , 19 60 , and that death occurred at 10:22 M, from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane M.D.				22b. DATE SIGNED June 4 1960			
22c. PHYSICIAN'S NAME (Type) W. O. McLane,				22d. ADDRESS " Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-4-60		23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		23d. LOCATION (City, town, or county) (State) Eckhart, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Luster				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE JUN 8 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

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WILLIAM H. HARRIS

WILLIAM H. HARRIS

WILLIAM H. HARRIS

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WILLIAM H. HARRIS

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6487

CERTIFICATE OF DEATH

06452

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X R.F.D # 1 Frostburg d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Last Steele		4. DATE OF DEATH Month June Day 22 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1888
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Klondyke, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Cutter	
14. MOTHER'S MAIDEN NAME Ellen Humberson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT James Steele Address Gilmore, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 4-20-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary & Generalized sclerosis with chronic heart insufficiency DUE TO age (c) had severe Virusinfection with bronchopneumonia 2 months ago		INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) had severe Virusinfection with bronchopneumonia 2 months ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-21-60 19 to 6-22-60 19, that (I) (we) last saw the deceased alive on 6-20-1960 and that death occurred at 5:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Otto Vogel M.D.		22b. DATE SIGNED 6-23-60	
22c. PHYSICIAN'S NAME (Type) Otto Vogel, M.D.		22d. ADDRESS 167 East Main, Frostburg, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/25/60	
23c. NAME OF CEMETERY OR CREMATORY Steele Cemetery		23d. LOCATION (City, town, or county) (State) Near Lonaconing, Md	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25. RECORD BY REGISTRAR JUN 27 60	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

(M)

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NAME _____

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6471

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>02</u> years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>440 North Mechanic Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET HANNAH STEELE</u>		4. DATE OF DEATH Month Day Year <u>June 4 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1882</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Braddock Farms, Alleg. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Steele</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Louise Kerr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. James Kerr</u>		<u>119 Valley Street</u> <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC CONGESTIVE HEART FAILURE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OSTEOPOROSIS, DEGENERATIVE ARTHRITIS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 APRIL</u> , 19 <u>60</u> , to <u>4 JUNE</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1 JUNE</u> , 19 <u>60</u> , and that death occurred at <u>5:00AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>William P. James</u> M.D. <u>6-6-60</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>William P. James</u> M.D. <u>441 N. Centre St. Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

CERTIFICATE OF DEATH

1947



Place of Birth

Usual Residence

Age

Sex

Occupation

Years

Married

Date and Place of Death

Signature of Physician

Signature of Registrar

Signature of Informant

1947

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Date

CHRONIC CONGESTIVE HEART FAILURE

ARTERIO-SCLEROTIC HEART DISEASE

OSTEOPOROSIS, DEGENERATIVE RHEUMATISM

21 April 1947

1 June 1947

1947

Signature of Informant

Signature of Informant


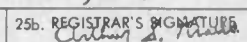
Signature of Informant

Signature of Informant

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6472

06454

1. PLACE OF DEATH a. COUNTY ALLEGANY b. STATE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			c. LENGTH OF STAY IN 1b 10 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, MARYLAND							
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				d. STREET ADDRESS 106 WEST SECOND ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First GREGORY Middle MILTON Last STEWART				4. DATE OF DEATH Month JUNE Day 24 Year 19 60									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 14, 1960		9. AGE (In years lost birthday) yrs. 10		IF UNDER 1 YEAR Months 10		IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME MILTON J. STEWART						14. MOTHER'S MAIDEN NAME LA VERNE M. EVANS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Patent Ductus Arteriosus 754.1 DUE TO Patent Foramen Ovale Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hemorrhagic Kidneys (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Stenosis Descending Colon												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 8:29, P.M. the causes and on the date stated above.													
22a. SIGNATURE 						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 27 June 60					
22c. PHYSICIAN'S NAME (Type) DR. F.B. WHITWORTH						22d. ADDRESS 123 BEDFORD ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-27-60		23c. NAME OF CEMETERY OR CREMATORY St. Patrick Cem				23d. LOCATION (City, town, or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli						ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUN 28 60		25b. REGISTRAR'S SIGNATURE 			

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CERTIFICATE OF DEATH

1942

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6473

06455

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>1209 Union Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>J</u> Middle <u>WAGNER</u> Last				4. DATE OF DEATH <u>June</u> Month <u>5</u> Day <u>1960</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/5/94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>George Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Estella Martz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>War I</u>				16. SOCIAL SECURITY NO. <u>217-10-4240</u>			
17. INFORMANT <u>Mrs. Frank Wagner, Cumberland, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>on benzylol antineoplastic drugs</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1960</u> to <u>June 5, 1960</u> that (I) (we) last saw the deceased alive on <u>June 4, 1960</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>B. Schindler</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>Dr. B. Schindler.</u>							
22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 8, 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 9 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

• 1985 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6474 CERTIFICATE OF DEATH

06456

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 1 632 N CENTER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CARL Last WEISENMILLER				4. DATE OF DEATH Month JUNE Day 1 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/13/97 1/13/97	
9. AGE (In years less birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Cumb. Brewery		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WEISENMILLER				14. MOTHER'S MAIDEN NAME ANNA SCHMIDT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W.W.# 1				16. SOCIAL SECURITY NO. 214-05-4841		17. INFORMANT Mrs. Pearl Weisenmiller Address Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 acute coronary occlusion DUE TO (b) arteriosclerotic heart disease DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mo							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-4 to 6-1 , that (I) (we) last saw the deceased alive on 6-1 19 60 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. Brings				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/60	
22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS				22d. ADDRESS 57 GREENE STREET Cumb. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/60		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 6 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Harris	



RECEIVED
FBI
JAN 11 1964

6475

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2yrs. 1mo. 13da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Rose Last Weston		4. DATE OF DEATH Month June Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/80
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Rose		14. MOTHER'S MAIDEN NAME Elizabeth Brust	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sylvan Retreat Cumb. Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Chronic Myocardial Ischemia DUE TO 304X Conditions, if only which gave rise to immediate cause (a), stating the underlying cause last. (b) 456 General arteriosclerosis DUE TO (c) 304 Senile psychosis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 171 Malignant neoplasm cervix uteri		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 25th 1958 to June 7th 1960 , that I last saw the deceased alive on June 6th 1960 , and that death occurred at 10:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		DATE SIGNED 6/8/60	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/60	
22c. NAME OF CEMETERY OR CREMATORY County Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md		ADDRESS	
24a. REC'D BY REGISTRAR JUN 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6265 6-23-60 et

6476

CERTIFICATE OF DEATH

06458
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hosp.		d. STREET ADDRESS 314 Fayette St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hannah Middle Jane Last Willetts		4. DATE OF DEATH Month June Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Franklin, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Whitefield		14. MOTHER'S MAIDEN NAME Catherine (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. John Willetts		Address 314 Fayette St., Cumb.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene, Intestinal 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mesenteric Thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Umbilical Hernia		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14 , 19 60 , to 6/15 , 19 60 , that I last saw the deceased alive on 6/14/60 , 19 60 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 456 N. Centre St., DATE SIGNED 6/15/60	
ACTUAL SIGNATURE Leo H. Ley Jr.		M.D. 456 N. Centre St.,	
PHYSICIAN'S NAME (Type) Leo H. Ley Jr. M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/60	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JUN 20 '60		24b. REGISTRAR'S SIGNATURE Charles L. George	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF PHYSICIAN		NAME OF SURGEON	
NAME OF NURSE		NAME OF MIDWIFE	
NAME OF DENTIST		NAME OF OPTICIAN	
NAME OF PHARMACEUTIC		NAME OF LABORATORY	
NAME OF HOSPITAL		NAME OF CLINIC	
NAME OF DISPENSARY		NAME OF PHARMACY	
NAME OF STORE		NAME OF RESTAURANT	
NAME OF BAR		NAME OF CAFE	
NAME OF CLUB		NAME OF GYM	
NAME OF PARK		NAME OF GARDEN	
NAME OF LAKE		NAME OF RIVER	
NAME OF MOUNTAIN		NAME OF HILL	
NAME OF VALLEY		NAME OF PLAIN	
NAME OF COAST		NAME OF ISLAND	
NAME OF TOWN		NAME OF CITY	
NAME OF COUNTY		NAME OF STATE	
NAME OF COUNTRY		NAME OF WORLD	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06459**

6477

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 318 Arch St.				d. STREET ADDRESS 318 Arch St.			
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Williams, Sr.				4. DATE OF DEATH Month June Day 18 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1884		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75 Days 75	IF UNDER 24 HRS. Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David A. Williams				14. MOTHER'S MAIDEN NAME Eliza Dix			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-4509		17. INFORMANT Address Mrs. John T. Williams, Cumberland Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 19, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-21-1960	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR JUN 21 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06460

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt #2 Flintstone		c. LENGTH OF STAY IN 1b 11 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Claude Middle R Last Wilson		4. DATE OF DEATH Month June Day 2 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1880
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Penna	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Wilson		14. MOTHER'S MAIDEN NAME Elizabeth Robinette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-30-8654	
17. INFORMANT Ralph Wilson		Address Cumberland Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Sudden		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 15, 1960 to June 2, 1960 , that (I) (we) last saw the deceased alive on June 2, 1960 , and that death occurred at 11a M, from the causes and on the date stated above.			
22a. SIGNATURE Benedict Skitarelic		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Benedict Skitarelic, M.D.		22d. ADDRESS R.D. # 9 Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/60	
23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d. LOCATION (City, town, or county) (State) Flintstone Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR JUN 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

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— *Journal of the American Medical Association*

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

06461

6501

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Near Cumberland</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box #157 Oldtown Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>WILSON</u> Last <u>WILSON</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 14, 1881</u>		9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly-Springfield Warriors Mt.</u>		11. BIRTHPLACE (State or foreign country) <u>Allegany Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>OLIVER WILSON</u>			
14. MOTHER'S MAIDEN NAME <u>EMILA TWIGG</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-20-6738</u>				17. INFORMANT <u>Baltimore Pike Mrs. John Raines, Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2 Malaria</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension & decomposition</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> 19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1958</u> to <u>June 12 1959</u> that (I) (we) lost saw the deceased alive on <u>June 12 1960</u> and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clayton E. Durrett</u>				22b. DATE SIGNED <u>June 12 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>Clayton E. Durrett M.D.</u>	
22d. ADDRESS <u>236 Va. Ave., Cumberland, Maryland</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. PHYS. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 15, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUN 16 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

06501

CERTIFICATE OF DEATH

06501

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *65*
4. Date of death: *10/15/1965*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Signature of physician: *[Signature]*
8. Signature of registrar: *[Signature]*
9. Date of registration: *10/20/1965*

10. Name of informant: *John Doe*
11. Address of informant: *123 Main St, City, State*
12. Signature of informant: *[Signature]*
13. Date of interview: *10/20/1965*
14. Name of registrar: *John Doe*
15. Address of registrar: *123 Main St, City, State*
16. Signature of registrar: *[Signature]*
17. Date of registration: *10/20/1965*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6478

CERTIFICATE OF DEATH

Reg. Dist. No.

06462

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Cumberland St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle WILLIAM Last WOLFORD		4. DATE OF DEATH Month June Day 15 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Store Prop.		10b. KIND OF BUSINESS OR INDUSTRY Groceries	11. BIRTHPLACE (State or foreign country) Allegany Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Frank Wolford	
14. MOTHER'S MAIDEN NAME Mary Schlunt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,	
16. SOCIAL SECURITY NO. 215-20-5140		17. INFORMANT Miss Mary C. Wolford Address 412 Cumb. St. Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 6/14 , 19 55 , to 6/15 , 19 60 , that I last saw the deceased alive on 6/14 , 19 60 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6/15/60			
ACTUAL SIGNATURE Leo H. Ley Jr.		M.D. 456 N. Centre St.,	
PHYSICIAN'S NAME (Type) Leo H. Ley Jr. M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/17/60	22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 20 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6479

Reg. Dist. No. 06463

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md.		c. LENGTH OF STAY IN 1b 12 Cumberland Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 210 Valley Street.			e. STREET ADDRESS 210 Valley Street.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) SUSIE ANNA WOLZ			4. DATE OF DEATH June 4 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 23, 1890		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Artemas Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Asberry Perdew		
14. MOTHER'S MAIDEN NAME Emily Johnson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		
16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Charles E. Wolz. 210 Valley St. Cumb. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (c) DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 4, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 7, 1960	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS 117 Frederick Street.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
		24c. REC'D BY REGISTRAR JUN 7 '60		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO BE COMPLETED BY THE PHYSICIAN

ALLIANCE

UNDERSTANDING

IN VALLEY STREET

DEATH

Yakov

Hebrew

Hebrew

101

None

1. Thomas A. Jones, 11 Valley St. Corp. 11.

IN CASE OF DEATH THE PHYSICIAN SHALL FILL IN THE FOLLOWING INFORMATION:

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Date of completion

10. Initials of physician

ALLIANCE

UNDERSTANDING

IN VALLEY STREET

DEATH

Yakov

Hebrew

Hebrew

101

None

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Date of completion

10. Initials of physician

ALLIANCE

UNDERSTANDING

IN VALLEY STREET

DEATH

Yakov

Hebrew

Hebrew

101

None

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Date of completion

10. Initials of physician

ALLIANCE

UNDERSTANDING

IN VALLEY STREET

DEATH

Yakov

Hebrew

Hebrew

101

None

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Date of completion

10. Initials of physician

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6480

CERTIFICATE OF DEATH

Reg. Dist. No. 06464

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Irons Mountain		d. STREET ADDRESS Irons Mountain	
3. NAME OF DECEASED (Type or print) First Nettie Middle Hannah Last Zimerly		4. DATE OF DEATH Month June Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1880
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Conrad Shatzer	
14. MOTHER'S MAIDEN NAME Sidney Daniels		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Hervey F. Zimerly Address Irons Mountain	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/12 , 19 60 , to 6/8 , 19 60 , that I last saw the deceased alive on 5/15/60 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George M. Simons M.D.		Algonquin Hotel, Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. George M. Simons, MD		June 10, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 10, 1960	22c. NAME OF CEMETERY OR CREMATORY Davis Memorial	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krawe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

